ENROLLMENT / CHANGE / CANCELLATION FORM

UnitedHealthcare of Ohio, Inc.

For Plan Use Only:

A. EMPLOYER AUTHORIZATION (FOR EMPLOYER USE ONLY)

Group Number	Company Name	Dept. No.	Requested Effective Date: / /	Approved By:	Date: / /

B. ACTION *(COMPLETE APPLICABLE BOX BELOW)*

New Enrollment/Additions (check one)

- ☐ New Hire - Date of Hire:_____ /_____ /_____
- ☐ Open Enrollment
- ☐ Status Change (PT to FT) on ____ / _____ /_____
- ☐ Return from Leave/Layoff on ____ / _____ /_____
- ☐ Birth (enter child's name and date of birth in Section D)
- ☐ Marriage on_____ / _____ / _____
- ☐ Adoption (attach legal documentation)
- ☐ **Other (describe)**_____

Cancellations (check all that apply)

- ☐ Cancel all coverage
- ☐ Cancel only: ☐ Dental ☐ Life ☐ Medical
- ☐ Cancel dependents listed below - Section D

Reason: (check one) ☐ Death ☐ Divorce ☐ Moved out of Service Area ☐ Employee Terminated ☐ Dependent reached student/depend. maximum age

- ☐ Other (describe) _____

Change: (check all that apply)

- ☐ Transfer from Group No. _____ to Group No. _____
- ☐ Change Address (enter new address in **Section C)**
- ☐ Change Name (enter new name in **Section C or D)**
- ☐ Electing Continuation Coverage
- ☐ Change in Other Health Insurance Information (complete **Section E**)
- ☐ Change Product or Selection
- ☐ Change Beneficiary (complete **Section F**)
- ☐ Other (describe)

C. EMPLOYEE INFORMATION

Employee Social Security Number	First Name	M.I.	Last Name	Marital Status: ☐ Single ☐ Married	Employer's Company Name/Division	Employee Status: ☐ Full Time ☐ Part Time ☐ Retired	☐ Salaried ☐ Hourly ☐ Exec.	☐ Bargaining ☐ Non-Bargaining

Home Street Address | City | State | Zip Code | County

Home Phone ( ) | Work Phone ( )

D. FAMILY INFORMATION Employee, Spouse, Dependents to be enrolled, cancelled, changed: (attach extra sheet, if needed.)

Coverage will not be offered to a dependent living outside the service area, unless he/she is a full-time student or coverage is required by court decree. If you are required by court decree to provide coverage for any dependent listed below, please attach a copy of the decree.

Check Appropriate Box	Relationship	First Name	M.I.	Last Name	Sex	Date of Birth (MM/DD/YY)	Social Security Number	Resides with Employee	Other Medical Insurance	Insurance Company Name (If Medicare, Complete below)	Policyholder Name & Policy Number	Policyholder's Employer Name	Policy Coverage Dates
☐ Enroll ☐ Cancel ☐ Change	EMPLOYEE				☐ M ☐ F	/ /		N/A	☐ Yes ☐ No				From: To:
☐ Enroll ☐ Cancel ☐ Change	SPOUSE				☐ M ☐ F	/ /		☐ Yes ☐ No	☐ Yes ☐ No				From: To:
☐ Enroll ☐ Cancel ☐ Change					☐ M ☐ F	/ /		☐ Yes ☐ No	☐ Yes ☐ No				From: To:
☐ Enroll ☐ Cancel ☐ Change					☐ M ☐ F	/ /		☐ Yes ☐ No	☐ Yes ☐ No				From: To:
☐ Enroll ☐ Cancel ☐ Change					☐ M ☐ F	/ /		☐ Yes ☐ No	☐ Yes ☐ No				From: To:

Complete the following for any family member covered by Medicare: Name of family member | Medicare Claim Number | Part A Effective Date / / | Part B Effective Date / / | Is Medicare eligibility due to: ☐ Kidney failure ☐ Disability

E. OTHER HEALTH INSURANCE - Failure to complete this section may result in claims being disallowed until information is provided.

On the day your coverage begins will any family members be covered by other health insurance, including another UnitedHealthcare policy, or Medicare
If yes, complete questions below. (Attach additional sheet, if needed)

F. PRODUCT SELECTION *(CHECK ALL THAT APPLY)*

Non-Network benefits provided by UnitedHealthCare Insurance Company of Ohio.
Non-Medical products provided by UnitedHealthCare Insurance Company.

MEDICAL BENEFITS:
- ☐ Employee Only
- ☐ Employee + 1 or more Dependents
- ☐ No Medical Coverage*

DENTAL BENEFITS:
- ☐ Employee Only
- ☐ Employee + 1 or more Dependents
- ☐ No Dental Coverage*

***** "No Coverage" box(es) above MUST be checked if coverage is **waived**

OTHER NON-MEDICAL BENEFITS:
- ☐ Employee Life/Accidental Death & Dismemberment
- ☐ Dependent Life
- ☐ Supplemental Life

BENEFIT LEVEL (EMPLOYER USE ONLY)

Salary Per: ☐ Week ☐ Year ☐ Month
$

Your Beneficiary's Full Name
Relationship:

Contingent Beneficiary (If applicable)
Relationship:

G. SIGNATURE *(FORM* **MUST** *BE SIGNED FOR ANY ENROLLMENT, CHANGE OR CANCELLATION ACTIVITY)*

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION. On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give UnitedHealthcare of Ohio, Inc. or any of their designees any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by Us on this application may invalidate my and/or my dependents' coverage. FRAUD WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

UnitedHealthcare®
A UnitedHealth Group Company

X_____/ ___/ ___
Employee Signature | Date Signed

X _____/____/ ___
Spouse Signature | Date Signed

OH 50A (10/00)

For Employer Use Only: *
Submit completed applications to UnitedHealthcare at the mailing address of Fax number listed below.

Mailing Address (for all groups located in Ohio)

Ohio Enrollment
MN002-0240
P.O. Box 1459
Minneapolis, MN 55440-1459

Or Fax to the number below:
(952) 833-6105

Employees: *Please do* **not** *mail or Fax this form directly to UnitedHealthcare.* Give the completed form to your employer or group administrator who will submit to UnitedHealthcare.